motivation. Relatively simple interventions given at an early stage can be surprisingly effective. This is encouraging because low cost techniques for early recognition and intervention can be utilized widely within the primary health care system. At present, only a minority of those who are drinking in a harmful way obtain relevant help.

Mutual-help groups have obvious financial and social advantages. Alcohol Anonymous continues to make an enormous contribution to the rehabilitation of alcoholics. Self-help, health promotion and other materials are providing encouraging results particularly for the individual who is drinking in a hazardous way without yet developing evident harm. The boundary between treatment and prevention is rightly blurred and several techniques are relevant to both activities. Prevention by means of reduced availability and the creation of sensible attitudes towards drinking are an essential backdrop for any effective treatment endeavour. In this particular sphere prevention is very much more cost-effective.

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Barriers to education about alcohol

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Introduction

Several recent surveys have shown that teaching about alcohol in medical schools both in this country[1-3] and in the United States[4] is less than ideal (Table 1). Postgraduates faced with alcohol problems in their practices also express frustration at their lack of knowledge and inability to respond[5], and formal testing has shown that up to half are deficient in factual knowledge. Things are improving in Britain, partly as a result of educational efforts by such bodies as the Medical Council on Alcoholism and Alcohol Concern, but also because alcohol misuse is so common that professionals - and that includes medical students - can hardly fail to be aware of it. Even so knowledge is patchy, alcohol misuse is frequently given poor coverage in teaching programmes and the whole subject is rife with myths and prejudices. It may be instructive to analyse some of the latter in order to expose barriers to education.

Alcohol problems are so widespread that students are bound to learn all about them during the medical course

Unfortunately a process of osmosis or even repeated exposure to the delights of alcohol is not sufficient.

Table 1. An American view of alcohol education

4	4 years in medical school
|	
2	2 hours' teaching on alcohol
|	
1	the No. 1 problem in the US

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A session during attachment to psychiatry or seeing patients damaged by cirrhosis or dementia by which time the role of alcohol is barely relevant is unhelpful and off-putting. Alcohol embraces so many elements of the human condition that it could be taught to medical students throughout their training as an example of the interaction between health, medicine and society (Table 2). What is needed is a more formal presentation of alcohol - not just alcohol misuse - in both preclinical and clinical years. Masterminded by someone with a special interest, staff from many different disciplines should be involved and particularly those like psychologists, social scientists and counsellors who are not medically qualified. The emphasis should be on the role of alcohol in society, health promotion and prevention of problems, the value of a team approach, and the importance of social rather than medical harm. Can a comprehensive programme be accommodated within the present curriculum? A minimum of one formal session of four hours in each of the preclinical and clinical courses, supplemented by references to alcohol wherever relevant, could provide the basis for future practice.

Table 2. The ramifications of alcohol

Anthropology	Biology
Archaeology	Psychology
Arts	Sociology
Religion	Epidemiology
Agriculture	Health
Economics	Medicine
Law	

I am a gastroenterologist. I do not see patients with alcohol problems

The belief among doctors that alcohol misuse is someone else's problem is strong. They, of course, drink like other people (sometimes heavily) and may see no harm in it, but the real reason for attempts not to notice is almost certainly lack of knowledge leading to denial and a feeling of threat when confronted. In defence they could justifiably point out that serious medical harm is found in less than 10% of problem drinkers (Table 3).

So should doctors be involved? Four-fifths of the population visit a general practitioner in a 3-year period; one in four or five hospital admissions is alcohol-related. There is therefore a great opportunity for doctors (i) to recognize the early consequences of heavy drinking before damage becomes irreversible; (ii) to spot the much commoner social and economic hazards; and (iii) to offer effective advice and help with changes in lifestyle. Progressive general practitioners have already responded to the challenge.[6,7] Hospital doctors have been inhibited by their devotion to a specialism which labels the 'alcoholic' as a psychiatric problem. General physicians, surgeons and even psychiatrists[8] still do not routinely take and record an alcohol history; what hope is there for orthopaedic surgeons and gynaecologists?

A broader view by hospital doctors of diseases and their social overtones would help to expose the frequency of alcohol misuse as a factor in all sorts of ill health[9]. Even now, for example, when the coroner no longer needs to be informed if alcohol contributes to death, doctors are reluctant to mention it on death certificates[10]. If we were more open alcohol would find its rightful place in the mainstream of medicine.

Table 3. Problems caused by alcohol misuse

Housing	2%
Work	23%
Domestic	26%
Legal	25%
Medical	6%
None	18%

Medical students also need to be taught just as enthusiastically about the more prosaic virtues of preventive medicine as they are about the triumphs of high tech medicine. In this way the balance might shift a little towards prevention and perhaps save some of the expense of so-called curative medicine. A liver transplant for a patient with alcoholic cirrhosis costs £25 000; treatment of a patient with cirrhosis from the time of diagnosis to death has been put at £20 000 by one regional health authority; a small alcohol agency in London sees 200-300 problem drinkers a year on a budget of £24 000. Is it possible or indeed justifiable to compare the cost effectiveness of each of these?

Substance abuse is an unpopular subject; we have to do it because we need it for our exams

This is a common view, not confined to trainee psychiatrists from whom the quote is taken; it probably originates from the negative messages received as students. Yet alcohol misuse provides an intellectual and practical challenge as great as any in medicine; it embraces individual health and behaviour, the attitudes of society, and management of complex therapeutic issues; and many unanswered questions await anyone interested in research.

Considering the prevalence of alcohol problems in Britain the medical profession has been slow to recognize the need for specialists, who would stimulate interest and raise the profile. The Scandinavian countries, for example, each have several academic departments - we have two or three - and in the United States there are over 3000 physicians in addiction medicine. The torch in this country has been carried by a few enthusiastic doctors, though it is encouraging to see that health districts are increasingly asking for psychiatrists with an interest. Substance misuse has traditionally been the province of psychiatrists (because no one else wanted it?) but specialists in internal medicine and community medicine and general practitioners could equally well be involved. While it is good to see that the Royal Colleges are asking questions about alcohol in their examinations, they could perhaps do more to stimulate appropriate training programmes.

People don't tell the truth about their drinking

Many people are embarrassed in talking about alcohol - not least doctors. Yet doctors played a part in breaking down taboos about sex and death; they could do the same with alcohol. But they need to speak with confidence based on knowledge; they need to be aware of their own attitudes and prejudices and the likely response of their patients. One method is to include the topic in routine questions about smoking, exercise, diet and drugs, with a comment such as, 'I would like to ask you a few questions about your

lifestyle'. It does not take long: Wiseman *et al.*[11] showed that an adequate alcohol history can be obtained in two minutes in general practice. People who drink to excess may be reluctant to disclose their habits (there are simple techniques for making them talk), but they may also genuinely not know how much they drink. Attempts to discover the exact amount may be less important than exploring the circumstances of drinking and the role that alcohol plays in their lives.

Alcohol misuse is a hopeless case

Low expectations about treatment for alcohol misuse are universal. It would help if the experts were to admit that they can do little to alleviate alcohol dependence and that curative treatment of serious physical damage is rarely possible - hardly surprising given that they are the end result of years of damaging drinking. As a physician I find it helpful to regard the chronic alcohol misuser in the same way as a patient with chronic bronchitis or rheumatoid arthritis: I do not complain that they cannot be 'cured'.

The way to improve the therapeutic image must surely be to shift the emphasis towards promotion of healthy drinking and earlier detection of problems. The value of brief interventions at this stage has been shown both in general practice[6,7] and in hospital[12]. Pessimists say that uncovering problems will overwhelm services which are already stretched, yet doctors can do much themselves without having to seek specialist advice. They need, too, to shed their suspicion of cooperating with other health workers, since management of alcohol problems is a good example of the value of teamwork. They should also be prepared to learn from local alcohol agencies, whose members often know a great deal more about alcohol misuse than doctors and are only too willing to share their experience. Specialists will, of course, still be necessary to deal with difficult problems; all hospitals should have a consultant with an interest in alcohol misuse, who can also be involved in postgraduate training.

Conclusion

One of the difficulties about alcohol is that conferences such as this usually consist of the (worldly) wise leading the wise. Nothing I have said will surprise anyone in the audience; many of us have been saying similar things for a long time. But if we believe that knowledge among doctors is inadequate isn't it time for action rather than words? Do we have a consensus on what should be done? If so, could we produce a series of guidelines which would be acceptable to educational authorities? I would like to propose the following as some of the core topics that could be tested: alcohol history taking, communicating about alcohol, how to undertake early detection and health promotion, techniques of brief intervention, familiarity with types of socio-economic as well as physical harm, how to work in a team, and knowledge of community networks and specialist support. Finally, doctors might examine their own attitudes; they could influence public opinion, as they did over smoking, by keeping their own drinking within sensible limits.

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Primary care physicians and alcohol

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Introduction

Over the last 5-10 years there has been an increasing recognition of the importance of primary care physicians in the prevention and management of problems related to alcohol use[1,2]. A number of centres have developed initiatives in the field of primary care and alcohol and this has been supported by reports from governmental and non-governmental organizations[3-6]. The European office of the World Health Organization commissioned a series of three meetings on alcohol and primary care which culminated in a technical report publication[7]. The World Health Organization in Geneva has recognized the importance of primary health care and has initiated a number of collaborative projects developing screening instruments for use in primary

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